THREE RIVERS HOSPITAL
507 Hospital Way
Brewster, WA 98812
Okanogan County
(509) 689-2517

THREE RIVERS FAMILY MEDICINE
415 Hospital Way
Brewster, WA 98812
(509) 689-3749
Fax: (509) 689-9106

# COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): _____ DOB: ____/____/_____

Phone: _____ Mobile Phone: _____Email: _____
(This information will be used to contact you for your second dose reminder.)

Address: _____ City, State, Zip Code: _____

**Information collected in this section helps ensure we deliver equitable and patient-centered care**:
Sex listed at birth (check one):

| | |
|---|---|
| Male: ☐ | Female: ☐ |

Gender identity (check one):

| | | | |
|---|---|---|---|
| Male: ☐ | Female: ☐ | Non-Binary ☐ | Unspecified/Indeterminant: ☐ |

Ethnicity (Check one):

| | |
|---|---|
| Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐ | Not-Hispanic A person not of Spanish culture or origin ☐ |

Race: (Check all that apply):

| | | |
|---|---|---|
| Black or African American ☐<br>White ☐ | Asian ☐<br>American Indian or Alaska Native ☐ | Hawaiian or Pacific Islander ☐ |

## Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*
- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*
- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions.. If I have a history of certain allergic reaction(s), I must stay for 30 minutes. If I do not have a history of such an allergic reaction(s), I must stay for 15 minutes.*
- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*
- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*
- *I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

***Disclosure of Records:*** *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of Okanogan Douglas District Hospital (dba Three Rivers Hospital) I understand that it will keep records of this vaccination for me in Evident / CPSI and may keep my vaccination records in Okanogan Douglas District Hospital (dba Three Rivers Hospital)'s employee occupational health records, to the extent required or permitted by law.*

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Patient (or Parent/Guardian/Authorized Representative) Signature: _____ Date: _____

Name of Parent, Guardian, or Authorized Representative: _____ Date: _____

*If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.*

**Please mail your completed form to Three Rivers Family Medicine, PO Box 577, Brewster WA 98812.**

*Once you submit your form, please allow at least five business days for our team to contact you for an appointment. Thank you for your patience!*

***All sections below are for official use only:***

**Vaccine Administration Information for Immunizer:**

Administration date: _____ Administration time: _____

CVX (Product): _____

Dose number: _____

IIS Recipient ID: _____

IIS vaccination event ID: _____

Lot number: _____

Unit of Use MVX (Manufacturer): _____

Sending organization: _____

Vaccine administering provider suffix: _____

Vaccine administering site on the body: Left deltoid ☐ Right deltoid ☐ Other ☐ (indicate location) _____

Vaccine expiration date: _____

Vaccine route of administration: _____

Vaccination series complete (date): _____

Fact Sheet for Vaccine Recipients and Caregivers version date: _____

# Pre-Vaccination Checklist for COVID-19 Vaccines

## For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

**Patient Name** _____

**Age** _____

| | Yes | No | Don't know |
|---|---|---|---|
| **1.** Are you feeling sick today? | | | |
| **2.** Have you ever received a dose of COVID-19 vaccine? | | | |
| • If yes, which vaccine product?<br>☐ Pfizer<br>☐ Moderna<br>☐ Another product _____ | | | |
| **3.** Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? | | | |
| • Was the severe allergic reaction after receiving a COVID-19 vaccine? | | | |
| • Was the severe allergic reaction after receiving another vaccine or another injectable medication? | | | |
| **4.** Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | | |
| **5.** Have you received another vaccine in the last 14 days? | | | |
| **6.** Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | | | |
| **7.** Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | | |
| **8.** Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| **9.** Are you pregnant or breastfeeding? | | | |

**Form reviewed by** _____ **Date** _____

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Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

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